Hertfordshire Community NHS Trust

RY4

Community health services for adults

Quality Report

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Summary of findings

Locations inspected

Location ID	Name of CQC registered location	Name of service (e.g. ward/ unit/team)	Postcode of service (ward/ unit/ team)
RY402	Potters Bar Community Hospital		EN6 2RY
RY412	Queen Victoria Memorial Hospital		AL6 9PW
RY4X2	Queensway Operating Suite, QEII		AL7 4HQ
RY4X6	St Albans City Hospital		AL3 5PN
RY414	St Peters Ward, Hemel Hempstead General Hospital		HP2 4AD

This report describes our judgement of the quality of care provided within this core service by Hertfordshire Community NHS Trust. Where relevant we provide detail of each location or area of service visited.

Our judgement is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from people who use services, the public and other organisations.

Where applicable, we have reported on each core service provided by Hertfordshire Community NHS Trust and these are brought together to inform our overall judgement of Hertfordshire Community NHS Trust

Summary of findings

Ratings

Overall rating for the service	Good
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Good
Are services responsive?	Good
Are services well-led?	Good

Summary of findings

Contents

Summary of findings

Overall summary

We rated community health services for adults as good overall because:

There was a culture of incident reporting with consistent feedback and learning although this was not cascaded to all staff. The service was taking action to reduce new pressure ulcers and slips, trips and falls. The environments were visibly clean with the exception of the equipment at the Safari therapy clinic. Staff followed the trust policy on infection control. There was a shortage of nursing staff and a high number of vacancies.

Treatment and care was provided in accordance with evidence-based national guidelines. Although staff had access to training, the records showed that not all staff had completed their mandatory training. The managers said there were provisions for staff to receive their annual appraisals. Most staff said they had not received any clinical supervision but said that the managers had an open door policy and were available to discuss any issues or concerns.

Staff had awareness of the Mental Capacity Act (MCA) and the Deprivation of Liberty Safeguards (DoLS). DoLS.

Patients told us that staff treated them in a caring way and were kept informed and involved in the treatment they received. We saw patients being treated with dignity and respect.

The national referral to treatment time (RTT) of 18 weeks was not being met in some specialties. However, services were being developed to improve response to increased demand. We found examples where there were delays in discharging patients, particularly if they were waiting care packages or admission to a care home.

Support was available for people with a learning disabilities and reasonable adjustments had been made to services. An interpreting service was available and used. Patients reported that they were satisfied with how complaints were dealt with.

There was positive awareness among staff of the values of the trust and this included the expectations for patient care delivery across the trust. Some staff felt they received poor support during stressful periods. However, staff were able to speak openly about issues and incidents and this was positive for making improvements to the service.

Summary of findings

Background to the service

Hertfordshire Community NHS Trust (HCT) is responsible for delivering a wide range of community health services across Hertfordshire. The HCT serves the communities of Broxbourne, Dacorum, West Herts, Hertsmere, North Herts, St Albans, Stevenage, Three Rivers and Welwyn/ Hatfield. The HCT also provides a children's specialist community services in West Essex.

HCT delivers NHS services for people in the community for example the Integrated Community Teams (ICT). The teams consist of community nurses, physiotherapists and specialist nurses whose aims are to support patients being discharged from hospital back to their own homes.

The Home First service supports older people and others with long term or complex conditions to remain at home rather than go into hospital or residential care. The team is made up of nurses, social workers, therapists and home care workers. The Home First team works alongside GPs. The aim of the service is to help people stay well, independent and supported in their own home to enable them to get back into familiar routines and independent lifestyle.

The Rapid Response service offers a timely assessment and rapid social and health care input for patients who are in a “crisis” and would otherwise need a hospital admission.

Our inspection team

Our inspection team was led by:

Chair: Elaine Jeffers, Director of EJ Consulting Ltd, Bradford Hospitals NHS Foundation Trust.

Team Leader: Helen Richardson, Head of Hospital Inspections, Care Quality Commission.

The team of 29 included CQC inspectors and a variety of specialists: district nurses, a community matron, a GP, a community physiotherapist, a community children’s nurse, palliative care nurses, a specialist safeguarding nurse, specialist sexual health nurse, a dental nurse, a governance lead, registered nurses, and an expert by experience who had used community services.

Why we carried out this inspection

We inspected this trust as part of our ongoing comprehensive community health inspection programme.

How we carried out this inspection

To get to the heart of the experience of people who use services, we always ask the following five questions of every service and provider:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people’s needs?
- Is it well-led?

Before the inspection visit, we reviewed information that we held about these services, asked a range of other organisations for information and sought feedback from patients.

During the inspection, the inspection team visited:

- We visited eight patients in their homes and observed how staff were caring for people who use the service. This was with the informed consent of the person who used the service.

Summary of findings

- We spoke with 59 patients both on the phone and in person. We spoke with three carers.
- We spoke with the service managers for each service.
- We spoke with 61 other staff members; including doctors, nurses and therapists.
- We reviewed comment cards received from patients who use the services.

We also looked at 12 treatment records of patients and reviewed a range of policies, procedures and other documents relating to the running of the services.

What people who use the provider say

We spoke with 59 people who use the service and three relatives/carers. We received positive feedback from each person we spoke with.

Carers were positive about the care and treatment their relative had received. One carer said staff were, "Polite and helpful." Another said, "Staff are responsive" to peoples' needs and that they were able to ask questions. They said staff, "Do what they say and do not give up." They said they had "Nothing but praise in all areas."

People and their relatives were positive and said the service was "Very Good." They told us that they found staff to be wonderful. One person said the service was "Excellent and consistent." They said staff "Listened to their concerns and carefully explain what is happening."

Good practice

- The stroke team had been nominated by the trust management for the "life after stroke" award from the Stroke Association.
- The trust had set up a "task and finishing" group regarding recruitment. This was a new initiative exploring new development using an apprentice type scheme within the services. The locality managers said that four nurses had been recruited using this programme.

Areas for improvement

Action the provider MUST or SHOULD take to improve

Action the provider MUST take to improve

- The trust must ensure that clinical rooms must have, where appropriate, access to a hoist to support patients' and staffs care and welfare.
- The trust must ensure that the paper light records provide consent to care and treatment, the sharing of information and up to date care plans to ensure that visiting professionals can support patients' choices.
- The trust must ensure that all staff have completed their mandatory training.
- The trust must review the comprehensive discharge system between the acute services and the community services to identify areas of unsafe practice.

Action the provider SHOULD take to improve

- The trust should ensure that all staff are aware of how incidents' trends and outcomes are identified and cascaded to staff.
- The trust should ensure that there are systems in place to identify the cleanliness of equipment.
- The trust should ensure that the environment at St Albans Hospital is suitable for purpose.
- The trust should review the paper and electronic records to ensure that the recordings are accurate and do not contain variances and discrepancies.
- The trust should ensure that staff have regular supervision and annual appraisals.

Hertfordshire Community NHS Trust

Community health services for adults

Detailed findings from this inspection

Requires improvement

Are services safe?

By safe, we mean that people are protected from abuse

We rated safe for community health services for adults as requires improvement because:

There was a shortage of nursing staff and therapists, there was a high number of vacancies. Staff told us that they were worried about understaffing and the impact this had on the service.

The trust had introduced an electronic and 'paper light' system. We observed the paper light notes did not include details of a patient's consent to care and treatment and the sharing of information or their individualised care plans. This meant that visiting professionals may not have up to date information to support patients' choices.

Staff reported to us information technology (IT) connectivity issues and had to complete patient's records either on return to their office base or within their own homes. There was a risk of discrepancies being recorded between the paper and electronic records which may place people at risk of inappropriate treatment and care. However, the trust told us there was a mobile working operational policy which included guidance on work around actions in the event of poor connectivity.

Staff, where applicable, managed medicines well in the community. Patients were appropriately escalated to acute care if their condition deteriorated.

Staff followed the trust policy on infection control. The environments were visibly clean with the exception of the equipment at the Safari therapy clinic which appeared dirty. Equipment there did not have stickers to identify their cleanliness.

We observed peeling wallpaper, cracks in walls and damaged plaster at St. Albans Hospital. Some of the rooms where clinical care took place were small and cramped. Staff said, because of this, they were unable to use a hoist should a person fall to the floor. This meant that staff and people could be at risk of injury from poor manual handling practice. Staff said they had reported these concerns to the respective managers of the services.

The trust monitored the outcomes of patients with pressure ulcers, catheters, and falls. These were identified in the safety thermometer national audit.

Requires improvement

Are services safe?

The service had procedures for the reporting of all new pressure ulcers and slips, trips and falls. The safety thermometer records showed the trust was monitoring these and had taken action, where appropriate, to reduce the risk of new pressure ulcers, slips, trips and falls.

Handovers were well structured within the community services visited. This ensured that staff coming on duty were aware of any ongoing concerns.

Incident reporting, learning and improvement

Staff knew how to report incidents on the trust's electronic reporting system and how lessons were learnt from root cause analysis. Staff stated that incident reporting was good and said feedback was cascaded during team meetings and regular newsletters. However, some staff within the discharge planning team were unclear how the lessons learnt were routinely disseminated down to staff. The service managers reviewed and investigated local incidents whilst those of a more serious nature were investigated by senior management. We saw the trust produced a "lessons learnt" document twice yearly which was cascaded to staff. This meant that most staff had knowledge of learning from incidents across the organisation.

Staff had responded to an increase in falls by improving the monitoring of patients. We observed there had been a clear improvement in safety. Staff told us of their awareness of the risk of patients slipping, tripping or falling. We saw completed risk assessments which had identified the risk and actions to mitigate this.

The community nursing teams used the NHS safety thermometer. This is a tool used at the point of care to measure harm and the proportion of patients that had not suffered any harmful incidents during their stay. The safety thermometer looked at the incidence of pressure ulcers, falls and urinary tract infections. Analysis of the results was displayed for teams to see and discuss at team meetings.

Duty of Candour

Managers were aware of the duty of candour regulations and told us they were cascading this information to staff during team meetings. Staff were aware of the trust's policy of openness and transparency when things went wrong. The manager informed us they had not had to implement the duty of candour regulations with regard to any incidents.

Safeguarding

Staff demonstrated how they would report safeguarding concerns. We saw records included assessment documentation which had been amended to include the screening of people who were considered as being at risk of exploitation. We saw an example of where this had led to a prosecution in relation to safeguarding concerns.

The Home First team had a safeguarding lead within their team who said they would contact the relevant organisation for example, social services regarding any issues or concerns. All safeguarding concerns were reviewed by the senior managers.

The training records showed that staff had undertaken Level 2 training in safeguarding. We also saw that staff's refresher training due dates were included in the training record.

Medicines management

National Institute for Health and Care Excellence (NICE) guidance was followed when prescribing medication for individual patients. We observed the giving of insulin which was in line with these guidelines for patients diagnosed with type one diabetes.

We observed staff correctly disposing of a sharps box that was full. We saw medicine batch numbers being recorded prior to use. Medicines were stored in secure cupboards. This was in line with manufacturer's recommendations. Staff checked people's medicine dosage and ensured they were in date. Medicine sheets were clearly written.

Staff prompted people to access their medicines. Senior staff told us that staff did not administer medicines but encouraged and prompted people to access their medicines using a Monitored Dosage System (MDS). The MDS is a multi-dose reusable storage system designed to simplify the administration of medicines. The administration of medicines was discussed at community nursing team handovers to ensure that patients received their medicines safety and at an appropriate time.

The Home First service in Cheshunt had identified that people were being treated with multiple medicines. They identified the need of a pharmacist to be a part of the team to support people in this aspect of their care. We saw that the trust had acknowledged this and a pharmacist was due to join the Home First team on a one year pilot scheme.

Requires improvement

Are services safe?

Staff at the International Normalized Ratio (INR) clinic adhered to safe disposal of sharps using the sharps bin. INR refers to patients on long term or lifetime anticoagulation therapy who have their INR levels monitored by the taking of blood.

Safety of equipmentand environment

Staff could make a request to an external company for equipment for example, pressure relieving mattresses and the company responded within 24 hours to three days. However, there were no deliveries available at week-ends. Staff had access to equipment stored at their base office, which included for example, commodes and walking frames. Staff said that during weekends and out of hours there were problems with stock being taken and not replaced. We did not see a system in place to monitor the whereabouts of equipment. Staff said they had to try and track the equipment which was time consuming. The lack of a system to effectively monitor equipment stock and whereabouts impacted adversely on the efficiency and responsiveness of the service.

Staff at the Lister hospital said there were no systems in place to monitor the testing and calibration of equipment. For example, the portable appliance test (PAT) date for a syringe driver was out of date. Staff said they relied on patients informing them when a piece of equipment needed testing. We saw electrical leads trailing across the floor which could cause a trip hazard for staff and people visiting the Lister Hospital clinic. We saw the gym equipment at the Safari therapy clinic had been regularly tested. However, we saw that not all electrical plugs had the required PAT testing sticker which meant there was a risk that some electrical plugs may not have been appropriately checked to ensure their safety. Managers said they were aware of these issues and were looking at ways of monitoring equipment in the community.

At the Avenue clinic we observed multiple electrical equipment running from extension leads. This included for example, the trust's electronic recording system and a photocopying machine. We found that the gym equipment was dusty and did not have stickers to identify they had been cleaned. These concerns were reported to the locality manager for this service.

We saw treatment being carried out in single rooms which were well equipped with couches and hand washing facilities. The gymnasium at the Safari therapy clinic was well equipped. However, we did not see stickers to identify the equipment's cleanliness. We saw that some of the examination rooms used by the rapid response team at St Alban's hospital had peeling wallpaper, cracks in walls and damaged plaster. Staff said they had reported the damage to the maintenance department but had not been given any indication of when it would be repaired. Some rooms where clinical care took place were small and cramped. Staff were unable to use a hoist should a person fall to the floor due to the small environmental space. This meant that staff and people could be at risk of injury from poor manual handling practice.

Records and management

We looked at the electronic records of seven patients attending podiatry, lymphoedema and retinal screening clinics. The records showed that information included patient's medical history and allergies. We saw the records were updated immediately after each consultation with the therapist/clinician.

The trust had introduced a new electronic system. Staff said they had received good training and had a "buddy system" in place to support them with any problems. The trust had introduced a paper light operational process alongside the electronic system. The paper light documents were for the use of professionals visiting the patient in their home. This included emergency patient contact details, communication records of visiting professionals and staff. We observed the paper light notes did not include details of a patients' consent to care and treatment or the sharing of information. The paper light notes also did not contain patient's care plans. This meant that visiting professionals may not have up to date information to support patients' choices.

The district nurses' forms were not available on the hospital's electronic system which meant they had to print off a copy and e-mail the information. This meant there was a risk of patient's information being transmitted to the wrong person.

We saw the trust's electronic system was not compatible with the social service's recording system. District nurses were also unable to access the "Pathweb" system which was used for test requests by GP's and hospitals by using

bar codes and patient stickers. Nurses said they had to duplicate the information. This meant that staff were not always able to access up to date records from other practitioners particularly at weekends and evenings.

We observed a staff member accessing the electronic system which took over five minutes before losing the signal. This meant that they were unable to update their records. Staff said that 50% of their records had to be updated either on their return to their base on in their home environment. Staff said they had to remember the information which meant there was a risk of inconsistent recording of the treatment provided.

We examined three records completed by the integrated discharge team. They were clearly completed and structured which included patient's personal details.

Cleanliness, infection control and hygiene

Staff followed the trust's infection control policy. Staff were "bare below the elbow" and we observed staff using appropriate hand washing techniques. Staff had access to personal protective equipment (PPE) which included aprons and gloves. We saw staff appropriately disposing of gloves after single use. All the clinical areas had access to appropriate soap and hand washing facilities. Staff working in the community were supplied with hand gel.

We observed staff cleaning instrument and surfaces with antiseptic. Staff cleaned the couch after each patient. However, we did not find consistent practice across the trust regarding the use of a sticker system to inform staff that an item had been cleaned. This meant that staff could not be sure whether or not items had been cleaned, ready for re-use, in accordance with trust policy.

Mandatory training

Most staff said they had attended training. We found that training levels in some areas such as the Lister Hospital and the Royston community team were low. For example a third of staff had not completed their basic life support training, moving and handling and infection control. The training figures across the services were variable with training ranging from 50% for fire training to 80% for conflict resolution. Staff had received regular syringe driver and pressure ulcer updates. Any outstanding training had been identified and updated electronically to staff with due dates. District nurses reported that they undertook moving and handling training with the acute sector within the trust.

Senior staff said that low attendance rates led to operational pressures. Staff said they had to travel considerable distances for training and had problems getting protected time for training. However, we found that some of the courses could be undertaken via e-learning.

A new staff member said their mandatory training was covered as part of the induction process. They reported a good induction and said they had been assigned a mentor who had been very supportive. Some staff said they had to wait for their formal corporate induction process and had been in their post over eight weeks before receiving their induction. The trust told us that most local induction was completed within the first month. This meant that care delivery could be affected whilst staff were waiting for induction.

Assessing and responding to patient risk

Patients had individual risk assessments for example, the risk of developing pressure ulcers or falls. Risk assessments had been regularly reviewed and updated. We observed a pain assessment with the information been relayed to the relevant GP.

Patients referred to the podiatry services were assessed according to their needs. Patients at higher risk of foot ulcers or those with medical conditions affecting sensation in their feet were seen more urgently.

Staff demonstrated a high level of nursing care when responding to assessed patient risk. We observed staff undertaking a comprehensive approach to risk assessments on pressure ulcers, mobility concerns and people's nutritional needs.

Staffing levels and caseload

The Operations Development plan for 2014-16 had recognised the need to develop staff recruitment, skills, knowledge and values. The trust had set up a "task and finishing" group regarding recruitment. This was a new initiative exploring new development using an apprentice type scheme within the services. The locality managers said that four nurses had been recruited using this programme.

We looked at the staff rotas for January and February and saw that sickness levels had been recorded. Staffing issues were noted at the weekends and this was supported by those duty rotas seen. These vacancies had been filled by staff from other centres and agency workers.

Requires improvement

Are services safe?

The trust used caseload management guidelines for the integrated community teams. Each area within the trust had been grouped into ten care bundles. These guidelines identified the care intervention, the time allocated, the number of visits and the staffing level required. They also identified the clinical competencies required which included the attending of trust training and supervision.

District nurses told us they saw between 19 and 22 patients a day. This provided pressure on the service due to the complex clinical needs of some patients. The managers told us they reviewed staff's caseloads daily, taking into consideration patient's needs and the skill mix of the team. Evidence was seen that additional staff were used when the needs of patients required this.

The podiatrists said that their caseloads were 380 patients across the team. They said the target was 300 and they had added extra clinics to reduce the waiting times. Staff said they were on target and saw people within the expected waiting times.

The full time podiatry practitoners had a caseload of about 150 patients each in the podiatry services with a potential for 4,500 additional patients across the county. A business plan had been submitted for an additional specialist nurse as well as additional training for staff in the leg ulcer services to support this role.

Staff reported pressures from managers to accept additional referrals at short notice. These concerns had been escalated to the senior managers.

Managing anticipated risks

Community nursing teams had contingency plans in case of adverse weather conditions. Patients were categorised by need which ensured that in the event of a major disruption those requiring the most urgent care were prioritised.

Each location had a local risk register. For example, the services visited identified recruitment as an area of concern. The local risk registers identified the actions taken and the areas they were unable to address.

Staff described their action should a patient not answer the door. They gave a good account of the actions they would take. We asked the manager for the written protocol for staff to follow but thre was not one available.

The locality managers said they discussed any Central Alerting System (CAS) alerts at team meetings. The CAS provided safety critical information and guidance which could include equipment and medicines.

We reviewed the lone working policy and procedures. Staff were able to tell us of the lone working procedures and how they maintained safety in the community. The manager had acknowledged staff's concerns about lone working on the late shift and had encouraged peer support with colleagues in different localities.

Good

Are services effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

We rated effective for community health services for adults as good because:

The service demonstrated that care was provided in accordance with evidence-based national guidelines. The guidelines and pathways were used extensively, so that best practice was used to manage patient's care.

Policies and procedures were accessible for staff. Staff were able to guide us to the relevant information using the trust's intranet. Care was monitored to demonstrate compliance with standards and there were good outcomes for patients.

The care and treatment records showed us that patient's pain was appropriately managed as was the nutrition and hydration of patients. Multidisciplinary working was evident to co-ordinate patient care.

Staff had access to training. Most staff told us they had received their annual appraisals which incorporated their personal development. Most staff said they had not received regular clinical supervision.

Staff demonstrated a good understanding of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) and their assessments of mental capacity were detailed.

Clinical staff completed a comprehensive assessment of people who were referred. This included an assessment of people's physical health needs. The trust used both an electronic system and paper copies for recording and storing information about the patients' care.

Evidence based care and treatment

Care and treatment was being delivered in a holistic manner which promoted not only patient's physical health needs but also addressed their psychological needs.

Staff were able to show how they provided care and treatment to both patients and carers in line with the National Institute for Health and Clinical Excellence (NICE) guidelines. For example, the records identified the involvement of patients in partnership with their health and social care professionals and the stroke team followed the Royal College of Physicians and NICE guidelines.

The records we saw showed staff adhered to the NICE guidelines for the prevention of pressure ulcers. We saw pressure prevention equipment in place for example cushions and mattresses. The diabetic nurse specialist said they frequently had representatives bringing in NICE guideline updates for their review.

The trust reported to the Commissioning for Quality and Innovation (CQUIN) framework to improve the quality of services and the delivering of better outcomes for patients. We saw the results for 2013-14 which outlined the actual achievements made by the trust. For example the trust had achieved 100% in the actions taken to implement the National Dementia Strategy and 75% in their achievement of venous thromboembolism (VTE) risk assessments.

The records showed that staff within the lymphoedema clinics provided treatment in line with the Cochrane International Lymphoedema guidance. Therapists used the Malnutrition Universal Screening Tool (MUST) to raise awareness of a person's risk of malnutrition. This tool was used during the initial assessment of a person entering the service. The diabetic retinopathy screening followed the Royal College of Ophthalmologists clinical guidelines.

The integrated community team contributed to the Sentinel Stroke National Audit Programme (SSNAP).

Approach to monitoring quality and people's outcomes

We saw that the stroke team had established measurable goals for patients. These were written in user friendly language which encouraged the patient to take ownership of their individualised goals.

We saw comment cards from people. They were positive with many highlighting the care and attentiveness of staff.

The community nursing teams used the NHS safety thermometer. This is a tool used at the point of care to measure harm and the proportion of patients that had not

suffered any harmful incidents during their stay. The safety thermometer looked at the incidence of pressure ulcers, falls and urinary tract infections. Analysis of the results was displayed for teams to see and discuss at team meetings.

District nurses said that some ambulatory patients would be better served by their GP rather than use their services for example, for the administration of injections. The district nurses said this would allow them to manage their caseloads and capacity better. One of the locality managers said they were in conversation with GP's to see how they could manage patients more effectively who could attend their GP surgeries.

Waiting times for the leg ulcer clinics were variable for example; Hitchin clinic had a waiting time of nine weeks whilst Baldock clinic did not have any waiting time. Patients could be offered other clinics as deemed appropriate. We saw assessments of people's needs including pain management were comprehensive.

People who had not previously had a diagnosis of cancerous lymphoedema were seen within four weeks. Staff said they had achieved a target of seeing new patients within two weeks. The clinics did not have a waiting list for intensive therapy or review appointments. The lymphoedema reported monthly on non-clinical activity performance. This had resulted in the trust increasing the bandaging of patients with lymphoedema to twice a week. This had reduced waiting time for intensive treatment which meant there were no changes to patient's outcomes.

The waiting list for the musculoskeletal services from August 2014 to January 2015 showed breaches for each month. However, of the 29 apparent patient breaches appearing over 18 weeks, 13 were discharged with accordance with HCT Access policy, 12 were legitimate breaches, 2 were data quality issyes, in which cases the patient was seen within 18 weeks. During in this period there were two actual breaches resulting in referral to treatment time that was longer than 18 weeks.

Staff at Potters Bar Hospital said they were monitoring the "did not attend" (DNA) figures by reviewing the appointment letters and telephone text messages. They said it was a work in progress and that it was too early to review the effects of these new initatives on improved attendance. Patients who did not attend their appointments were offered another appointment. Patients were discharged if they did not attend again without a valid reason.

We reviewed the rate of DNA across the rheumatology services and this averaged 12%. We saw the DNA rates for the community nursing services which showed an average rate of 0.8%.

The trust had set a target of 80% for all referrals to the rapid response team being seen within 60 minutes. This had been achieved with figures of between 97% and 100%.

Staff told us they attended multidisciplinary meetings. There was good professional input from specialists and medical staff where present. Plans for progress and the resolution of issues for people were decided at the meeting. Staff were clear about the next steps for people who used the service.

Competent staff

The trust had made a strategic decision to increase the number of independent prescribers in the community team. Staff said this has been difficult to achieve due to the challenges of releasing staff for training. Specialist nurses said they received specialist two day training in their field as well as a university course for the running of clinics which enabled them to support others within their practice. Staff said they had completed their level two training in communication. The sexual health teams training were provided in line with the British Association of Sexual Health Education (BASHE) guidelines.

Staff said the trust were "exceptionally" supportive of specialised training for groups of staff. For example they funded the practice of metachromatic leukodystrophy (MLD) updates every two years. Metachromatic leukodystrophy is an inherited disorder characterized by the accumulation of fats in cells.

Some staff had undertaken the Diabetes Education and Self-Management for Ongoing and Newly Diagnosed (DESMOND) training. Staff said that DESMOND would enable them to discuss and educate people in the self-management of diabetes-related changes.

Staff had been trained in the use of the McKinley syringe driver in line with the Medicines & Healthcare Regulatory Agency (MHRA) guidelines.

Good

Are services effective?

Staff at the lymphoedemas clinic said they had monthly clinical supervision with a clinical psychologist. Some staff said they had continual professional development during their team meeting with external speakers.

The clinical psychologist for stroke said they trained rehabilitation assistants and patients in mindfulness to ensure that they were able to provide the correct care and welfare for people who use the service. Staff said they undertook "Stroke – decision making and update" and "motivational interviewing" external courses through the University of Hertfordshire.

The records for annual appraisals showed variances of between 55% to 76% completed appraisals across the service. Senior managers said they were aware of the shortfall and arrangements were in place for all staff to receive their appraisals. Some saff said they had not received recent clinical supervision.

Multi-disciplinary working and coordination of care pathways

Community teams told us that multi-disciplinary working was good. Staff felt able to consult with their colleagues. Specialist nurses were available to provide consultation when required. Community nursing teams and the specialist nurses worked well together and conducted joint visits where the assessed needs of patients required this.

Different therapists visited stroke patients based on assessed needs for example, a speech and language therapist or physiotherapist. The clinical psychologist saw all stroke patients under 50 and anyone with cognitive or emotional issues.

District nurses outlined a multi disciplinary approach to patient treatnment. For example with the tissue viability nurses, the leg ulcer specialist and the lymphoedema specialists.

Matrons worked in the Home First team but were available to provide advice to the integrated community team. Therapists worked across both teams. Patients were supported by different teams if their assessed needs changed. Patients had a named responsible clinician. The Home First team met GP's monthly to discuss the managed care of patients.

The therapist for hand therapy and rheumatology attended joint clinics with the acute services' consultants. Weekly meetings were also conducted with consultant surgeons. Staff had recently worked alongside the mental health team to review the Improving Access to Psychological Therapies (IAPS) therapies.

Referral, transfer, discharge and transition

Individual caseloads were reviewed which included the time frame for discharge from the service. Discharge was subject to a package of care being in place. Some staff said there were concerns with the discharge system from local acute hospitals. On occasions, the community teams were not being informed when patients needed the support of district nurses.

We saw that stroke patients who had been identified by the early support discharge team had goals in place prior to discharge for example, more physiotherapist input to improve mobility. The stroke team told us the information provided on discharge was not always accurate regarding the patient's condition and needs. Staff said they followed up hospital discharge problems by reporting them as incidents and speaking to ward staff.

Patients were given copies of all correspondence submitted to their GP or acute consultants with the exception of discharge letters. Staff said patients did not get a copy but confirmed the discharge letter was sent to their GPs.

The community health services received referrals from various sources for example, direct from the public or the GP services. The response time could range from one hour to a few days dependent on patient's need. When referrals were received into the lymphoedema clinic they were screened by the specialist nurse.

The community rheumatology orthopaedic and pain services (CROPS) received their referrals from GP's. Staff said that they saw 80% of the patient's referred with the other 20% being either referred to the orthopaedic department or back to the GP. There was a waiting list of 180 patients at Hemel Hempstead and 220 at Watford with a waiting time of between ten and twelve weeks. Patients accessed the CROPS service for a maximum of five weeks. Staff that there were available appointments within the clinics for emergencies.

Good

Are services effective?

Staff said that referrals for the hand therapy and rheumatology clinic had increased by approximately 30 patients each month. All referrals were triaged by the senior occupational therapist. Staff said their current caseload was 300 patients.

We saw the referral to treatment times for the podiatry services. The trust's records showed that the service had breached the 18 week referral time by 0.67%. We asked the manager to quantify the number of patients this affected but they were unable to provide us with the information.

Availability of information

The trust had access to interpreting and translation services from which they could arrange both face to face and instant telephone interpreting services. The interpreting service also included the translation of documents. Staff said they had used the facilities of the British sign language services.

The trust had produced literature to people accessing the community health service. This meant they had a good understanding of the service being provided. This could be requested, when required, in a different language or format

Consent

Staff were aware of the issues relating to confidentiality when entering a patient's house using the safe key system. Staff knew where the box number was kept and by whom.

Most staff demonstrated awareness of the Mental Capacity Act (MCA) 2005. They had received training and guidance regarding the MCA which was confirmed in the training records viewed. However, we saw that nearly half of the Royston community team had not completed their MCA training. This was brought to the attention of senior trust staff.

Photographs of people's pressure ulcers had the appropriate signed consent. However, we saw that consent was not obtained from people attending the retinal screening services. We were told that if a patient turned up they considered that as implied consent.

Patient's records included their consent to care and treatment and the sharing of information with others for example, their GP.

Good

Are services caring?

By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect.

We rated caring for community health services for adults as good because:

Staff were caring and compassionate to patient's needs and treated patients with dignity and respect. However, there were concerns with the environment at St Albans hospital with the potential risk of patient's dignity and respect being compromised.

Patients told us that staff treated them in a caring way, and were flexible in their support to enable them to access services. Patients and families said they were kept informed and felt involved in the treatment received.

Staff were kind and respectful to people and recognised their individual needs. Staff actively involved people in developing and reviewing their care plan and individual goals.

Dignity, respect and compassionate care

We saw positive examples of staff and people's interaction. We observed staff introducing themselves and ensuring patients were comfortable with our presence in their home. Staff treated patients with kindness and respect. They explained to us how they delivered care to the different people who use the service. This demonstrated that they had a good understanding of these different needs.

Patients were positive about the community nursing team. One patient said "These nurses are brilliant."

A patient we saw at one of the clinics said that the service was "absolutely marvellous" and another said they were sometimes in and out before their appointment time.

Patient understanding and involvement

We saw staff took time to ensure that patients understood their care and treatment and were involved in making decisions. For example, we saw staff showing a patient where they were going to take a wound swab and why.

One patient, who was under the care of the podiatrist said they carried a card and antibiotics which they could take at the first sign of infection. This had prevented admission into hospital for intravenous antibiotics.

Written information was available to patients about their care and treatment and medical conditions. These could be requested in a different language when required.

People were able to raise concerns and comments during their initial assessment meeting.

Emotional support

During our visit we observed the community nurses providing emotional support to people and relatives who were distressed. They spoke calmly and with respect whilst respecting the person's dignity.

Promotion of self-care

Staff supported patients to manage their own health care and maximise their independence. For example, we observed a health care assistant talking to a patient and giving practical advice to increase their mobility. Staff in the diabetic and high risk foot clinic gave verbal and written advice to patients.

Good

Are services responsive to people's needs?

By responsive, we mean that services are organised so that they meet people's needs.

Summary

We rated responsiveness for community health services for adults as good because as good because:

The services provided a range of specialist therapeutic interventions. The trust was aware of the diverse needs of the people who use the service and provided a range of support as required.

National waiting time targets of referral within 18 weeks were not being met in some specialities.

There was support for people with a learning disability and reasonable adjustments were made such as longer appointment times. Staff were able to refer any identified concerns to the trust's learning disability lead.

Information leaflets and consent forms were not available in easy-to-read formats. An interpreting service was available and used.

Patients reported that they were satisfied with how to make a complaint and how they were dealt with.

Planning and delivering services which meet people's needs

The integrated community teams offered a range of services dedicated to treating patients' requirements which included prevention of admission and the supported discharge service. The service was able to provide a range of different treatments and therapeutic interventions which included a physiotherapy and falls service.

The Home First's rapid response teams were able to respond to peoples' needs within one hour. If they were unable to meet the referral time staff said they continued to do background checks. Referral times were being met at the time of our inspection.

The staff at the Avenue clinic told us they had an overnight nursing service so that if a late call was received for example, a blocked catheter this could be dealt with by this service. The overnight service at the Avenue clinic was made up of one nurse and one health care assistant and provided an urgent response service for patients and their families.

There were 14 community clinics for lymphoedema. They saw people who had a diagnosis of lymphoedema due to cancer. Community nurses carried out Manual Lymphatic Drainage (MLD) on patients with hand, neck and trunk lymphoedema. Staff provided information leaflets for patients and their relatives.

There was a consultant cover for the diabetic service. The diabetic specialist nurse (DSN) said that they were able to phone the consultants who were happy to provide advice.

We observed staff speaking and discussing pain management with patients. We saw staff had good knowledge of pain management which they recorded on people's records. This ensured that people's needs were being discussed and provided.

The community rheumatology orthopaedic and pain service (CROPS) provided a service at Hemel Hempstead General Hospital and Watford General Hospital. The service was offered to adults with benign musculoskeletal (MSK) conditions where immediate surgery was not indicated and conservative treatment for example, physiotherapy had not been successful.

The trust ran a 12 week falls prevention course. The course invited patients who had been referred to the falls team. The physiotherapist technical instructor said that between eight and ten patients attended. However, this course was not commissioned for the patients living in the Royston area. The physiotherapist within this area has started a mobility clinic by undertaking assessments for patient's postural stability and falls risk and providing intervention guidelines. The physiotherapist said they currently held the mobility clinic monthly but would like to increase the clinic.

The trust had responded to the National Dementia Strategy by forming a living well with dementia project. The project aimed at improving the trust's approach to people living with dementia. The vision was to define the commissioning services' pathway by raising awareness and understanding through early diagnosis.

Patients attending the diabetic and high risk foot clinic were seen regularly, usually every three months, for a review of their condition and treatment. Patients were also able to phone the clinic with any problems between

Good

Are services responsive to people's needs?

appointments and where required urgent appointments would be arranged. New patients attending podiatry, physiotherapy and dietetic clinics were given longer appointments. This allowed extra time for assessment of the patient's condition and needs.

Equality and diversity

Staff we spoke with were able to demonstrate their understanding of equality and diversity. However, staff said they were unable to name the board member responsible for equality and diversity.

Meeting the needs of people in vulnerable services

The community nursing teams assessed patients with a diagnosis of learning disability to ensure they had access to specialist community learning disability staff when needed. Staff liaised with these nurses to ascertain if a patient had mental capacity and could give informed consent.

Community services had access to the Rapid Assessment, Interface and Discharge team (RAID) for patients who may have mental health problems alongside their physical health needs.

Access to the right care at the right time

Most staff in community teams said they could access standard pressure relieving cushions and mattresses. Bariatric equipment for obese patients was available when required.

Staff had access to the trust's speech and language therapist for advice and guidance to assist patients with communication difficulties. Referrals were made when necessary.

Complaints handling and learning from feedback

Staff said the administration team were often the first point of contact for complaints. They said the administration team offered the complainant the opportunity of putting their concern in writing before referring them to the Patient Advice and Liaison Service (PALS) if they were unable to resolve the issue locally. Staff supported people, their relatives or carers to make complaints as required.

Staff told us they received feedback and shared lessons learnt from complaints. They said complaints were discussed at team meetings. We read team meeting minutes across the community services visited but found no evidence that complaints were discussed ot that there was learning from them.

Good

Are services well-led?

By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Summary

We rated well-led for community health services for adults as good because:

There was positive awareness among staff of the values and expectations for patient care across the trust. Some staff identified concerns when their work load increased due to additional referrals. Senior managers said they were aware of the issues, and were monitoring the additional pressure.

The service held monthly clinical governance meetings where quality issues such as complaints, incidents and audits were discussed. Staff told us they were able to speak openly about issues and incidents, and felt this was positive for making improvements to the service.

Staff felt there was effective team working across professional groups in the community service. Patients were engaged through feedback. The test showed for example, that patients were given advice on any treatment given.

Innovation was encouraged from all staff members across all disciplines. Staff said they were encouraged to develop new ideas and to make continuous improvement in the service provided.

Service vision and strategy

The trust's vision was to, "Maintain and improve the health and wellbeing of the people of Hertfordshire and other areas served by the Trust".

Staff said they were clear about the values for the service. The trust had recognised the six core values (6Cs) which were launched by the Department of Health in December 2012. These are; care, compassion, competence, communication, courage and commitment. The trusts' aim was to provide accessible and responsive services that met the health needs of people who use the service.

However, some staff said they were unclear as to the direction and objectives of the organisation. They felt that the trust did not understand how things worked in the different localities especially the unplanned element of evening work which was very unpredictable.

Governance, risk management and quality measurement

Clinical quality leads for the service reported to the quality department. The managers said they were responsive and dealt with competence issues. However as there were only two clinical leads they felt they were limited to what they could cover.

Regular local audits were carried out and the findings used to improve practice. For example, the trust had acknowledged the need for a chronic oedema service. Clinical managers said they were considering introducing the service over the next financial year. Staff told us they did not receive feedback on completed audits.

There was a risk register for the adult community service and also local risk registers for the community nursing teams. Managers told us they updated the risk registers and escalated their concerns when necessary. We viewed the local risk register and found these had been updated with actions recorded regularly. Examples on the local risk registers included staffing.

Staff confirmed that they received e-mails from the trust giving updates on corporate developments. Team brief documents were circulated for staff to read. There were staff resources to deliver and monitor staff training on and off site and via e-learning.

Leadership of this service

Most staff spoke highly of the leadership within their teams although some staff said that recent changes meant that their teams lacked consistent supportive management. They felt that responsibilities were fairly shared out and all took turns in the allocation of work requests. Some staff

Good

Are services well-led?

members said they were unsure of the trust's intentions regarding the community nursing teams although they liked the introduction of the senior management team meeting.

Staff's morale within the trust was variable. For example, one staff said they, "Really enjoyed working here," and another said they felt, "Listened to and supported." However other staff said there was no forward planning or structure for their teams. Some staff said the shortage of staff meant they had to "pick up" other clients which meant they had to re-structure their travel arranagements. Staff said the managers did not always take into account the locations of different patients when allocating the rotas.

The locality manager said they saw their line manager regularly. Regular monthly meetings took place and staff told us that they felt supported by colleagues and managers.

Some staff said there was very little career progression due to the recent re-organisation of senior roles within the trust. They were aware of the chief executive officer's (CEO) plans to work on recruitment and retention but felt it would not work without the opportunity for career progression.

Staff were universal in their praise of the chief executive officer (CEO) and thought they were approachable and felt they were able to e-mail any concerns. One member of staff said they had been written to personally following an episode of excellent patient care. Some staff were unaware of the other members of the trust board and could not name the director of nursing.

Some staff perceived that their shift pattern was not flexible enough to meet work life balance. Whilst there were challenges with recruitment and retention of staff for the community services evidence was seen that the provider was taking action to pro-actively recruit and retain staff.

Culture within this service

Staff shared their views about the service openly and constructively. They were caring and passionate about the service and the care they provided to patients. Staff felt they worked well together as a team. A health care assistant told us they, "Enjoyed their job, I love looking after the people."

Public and staff engagement

Patient feedback was actively sought by staff. We saw the results and analysis were fed back to team members. Staff in the community nursing teams told us about initiatives to involve and engage staff. This included regular e-mails from the chief executive to staff. Information was sent to staff regularly by e-mail and newsletter. Staff were encouraged to regularly look at the staff intranet.

There was publicly available information about the services provided by the trust on their website.

Innovation, improvement and sustainability

The stroke team had been nominated by the trust management for the "life after stroke" award from the Stroke Association.

The trust had set up a "task and finishing" group regarding recruitment. This was a new initiative exploring new development using an apprentice type scheme within the services. The locality managers said that four nurses had been recruited using this programme.

Periodic service reviews had taken place to monitor the quality of the service with actions identified as relevant.